CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE	SURVEY LETED
I I I I I I I I I I I I I I I I I I I	of condition	155621	A. BUII			06/16/2	
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIER				TOCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER		I	SVILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	mayman		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	PRIATE	DATE
F0000							
	(PSR) to the Investion IN00088724 con This visit include Complaint IN000 This visit include Investigation of Complaint IN00089626, and on May 5, 2011. Complaint IN000 Survey dates:	ed the PSR to the Complaints IN00089836, d IN00089748 completed	F0	000	By submitting the enclos material we are not adm truth or accuracy of any findings or allegations. V reserve the right to conte findings or allegations as any proceedings and sul these responses pursual regulatory obligations. T requests that the plan of correction be considered allegation of compliance June 29, 2011 to the pos revisit conducted on Jun 2011. We respectfully rethat you review this infor request any further inforry you may require, and the consider a desk review.	itting the specific Ve est the spart of omit nt to our the facility I our effective st-survey e 16, quest mation, mation	
	Provider number AIM number: 10 Survey team:	ne Marie Crays, RN nsus bed type: F: 38 F/NF: 61 al: 99 nsus payor type:					
	Medicaid: 45						
LABORATOR	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

144K12

Facility ID:

000442

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/16/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET 3400 S	ADDRESS, CITY, STATE, ZIP CODE STOCKER DR SVILLE, IN47720	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Other: 34 Total: 99				
	Sample: 8				
		es also reflect state accordance with 410 IAC			
	Quality review co 2011 by Bev Fau	ompleted on June 20, Ilkner, RN			

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/16/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP CODE TOCKER DR VILLE, IN47720	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, print pr	n.c	00	COMPL	ETED
		155621	A. BUILDI B. WING	INU		06/16/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	t .			OCKER DR		
PINE HA	VEN HEALTH AND	REHABILITATION CENTER	I .		VILLE, IN47720		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	1	ΓAG	DEFICIENCY)		DATE
F0225	,	ot employ individuals who					
SS=D	· · · · · · · · · · · · · · · · · · ·	guilty of abusing, neglecting,					
	_	dents by a court of law; or					
		nave had a finding entered into the State nurse aide registry concerning abuse, neglect,					
		esidents or misappropriation					
		and report any knowledge it					
		a court of law against an	1				
		would indicate unfitness for	1				
		e aide or other facility staff to					
		de registry or licensing					
	authorities.						
The facility must ensure that all alleged							
		g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
		tely to the administrator of other officials in accordance					
		ough established procedures					
		tate survey and certification					
	agency).	tate carrey and continuation					
	3 - 7,						
	The facility must h	ave evidence that all					
	alleged violations	are thoroughly investigated,					
		further potential abuse while					
	the investigation is	s in progress.	1				
		and the same of th	1				
		nvestigations must be					
	•	ministrator or his designated					
	•	d to other officials in State law (including to the	1				
		certification agency) within 5	1				
		e incident, and if the alleged	1				
		d appropriate corrective	1				
	action must be tak		1				
		ew and record review, the	F022	25	F225 It is the practice of this		06/29/2011
		ensure a staff member	1		facility to assure that any form		
	[RN # 1] accused of abuse by Resident I was immediately sent home, and was				of abuse is reported to the Administrator immediately and		
					that any personnel involved		
	instead allowed t	to continue her shift for 5			removed from the schedule		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621		(X2) MUI A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE COMP. 06/16/2	LETED
	PROVIDER OR SUPPLIER  AVEN HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ΓΙΟΝ	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE OPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG			DATE
	hours, potentially affecting 39 residents			pending investigation.		
	residing on the North and South units on			corrective action taken those residents found		
	which the staff member worked, in a			affected by the deficier		
	sample of 5 Units, and 1 of 3 residents			practice include: There		
	reviewed for abuse in a sample of 8.			been no further abusive		
	The second secon			reported since the surve		
	Findings include:			exited. Resident I has s negative impact related documented incident. LF	to the	
	On 6/13/11 at 10:30 A.M., the			been individually educat		
	Administrator provided a "Facility			to the following of facility		
	1			Other residents that ha		
	Incident Reporting Form," sent to the			potential to be affected	l have	
	Indiana State Department of Health on			been identified by: Pote		
	6/10/11. The form included: "Brief			residents could be affect		
	Description of Incident:At 2:50 am [sic]			However, there have be		
	another aide responded to resident's call			allegations or observation incidents of abuse with a		
	light and resident stated that nurse had hit			residents since the surve		
	her. Night supervisor notified of			exited. <b>The measures o</b>	-	
	allegations" An accompanying			systemic changes that		
	statement, dated 6/10/11, indicated, "At			been put into place to		
	2:50am [sic] [CNA # 2] responded to			that the deficient pract	ice does	
				not recur include: The		
	resident's call light and states that resident			related to how to approp		
	told her 'that lady hit me again' and that a			intervene related to any	-	
	tall guy was with her. [LPN # 2], night			of abuse has been reiter all nursing staff member		
	supervisor was notified and spoke with			in-service was designed		
	nurse involved as well as resident. [LPN #			a thorough understandir		
	2] reports resident was 'pleasant and			policy including the repo		
	smiling' at this timeAt approx 9:00 a.m.,			abuse to the facility Adm		
	this administrator, the ADON, and the			and assuring that any pe		
	social worker met regarding the			against which the allega		
	incidentNo other alert/oriented residents			made are removed from pending the investigation	•	
				corrective action taken		
	had complaints of mistreatmentSW			monitor performance to		
	[social worker] also spoke with resident			compliance through qu		
	today and resident did not appear to have			assurance is: An	-	
	memory of any incident last night[RN #			updated Performance		

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	or connection	155621	A. BUII		00	06/16/2	
		.0002	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	3		1	TOCKER DR		
		REHABILITATION CENTER			VILLE, IN47720		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE
IAG	1	ed that she may return to	+	IAG	Improvement Tool will be util	ized	DATE
	work as scheduled."				to review the proper following the abuse policy, including removing any employees fro	g of	
	A facility "Employee Counselling [sic] Form," dated 6/11/11 and given to LPN #				schedule pending investigati		
					based on the allegation that		
	· ·	Type of Occurrence:			been made. The tool will be		
	Failure to immediately initiate suspension				utilized to review any allegat abuse. The Administrator, o		
	of staff member	when knowledge was			designee, will complete this		
	received of phys	ical abuse			as any allegations occur for		
	allegationSolution Discussed: Abuse policy review - with special focus on				next 6 months. Any issues identified will be immediately	,	
					addressed. The Quality		
	Reporting Proce	dures "Any staff member			Assurance Committee will re	view	
	alleged to have a	abused a resident will			the tool at the scheduled me		
	1	suspended from further			following the completion of the tool with recommendations a		
		e individual in charge of			needed. The date the system		
	the staff member	r will initiate the			changes will be completed		
	suspension"				June 29, 2011		
	On 6/14/11 at 12	·					
		rovided documentation					
		ked from 6/9/11 at 11:01					
	P.M. until 6/10/1	11 at 8:03 A.M.					
		25 A.M., during interview					
	· ·	e indicated she notified					
		isor at approximately 3:00					
	· ·	I that Resident I had					
	_	N # 1 hitting her. RN # 1					
	indicated she did	•					
		for the remainder of her					
	1 '	rk the remainder of her					
	shift.						
	1. On 6/15/11 at	8:45 A.M., the Assistant					

	IT OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP 06/16/2	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET A 3400 S	ADDRESS, CITY, STATE, ZIP C TOCKER DR VILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	facility policy on revised 2/11. The "Purpose, To er of abuse are invesubstantiationT will be relieved for pending investig."  This deficiency with 5/5/11. The facility of the relieved for the relieved f	ing provided the revised a "Abuse Prohibition," e policy included: insure that all allegations estigated fully for possible The alleged staff member from his/her duties ation"  was cited on 4/14/11 and ity failed to implement a correction to prevent				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>06/16/2</b>	ETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	p. ,,,,,	STREET A	ADDRESS, CITY, STATE, ZIP CODE FOCKER DR VILLE, IN47720		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F0226 SS=D	written policies and mistreatment, negland misappropriation Based on intervier facility failed to it on abuse prohibit member [RN # 1]. Resident I was not home, and was in continue her shift affecting 39 resident North and South member worked, and 1 of 3 resident a sample of 8.  Findings include:  1. On 6/15/11 at 3 Director of Nursiff facility policy on revised 2/11. The "Purpose, To end of abuse are investigationT will be relieved finding investigation	t for 5 hours, potentially lents residing on the units on which the staff in a sample of 5 Units, ats reviewed for abuse in 8:45 A.M., the Assistant ng provided the revised "Abuse Prohibition," policy included: asure that all allegations stigated fully for possible the alleged staff member from his/her duties ationScreeningEach member will be subject	F0	226	F226 It is the practice of this facility to assure that any for of abuse is reported to the administrator immediately at that any personnel involved removed from the schedule pending investigation in accordance with facility pole The corrective action taken those residents found to be affected by the deficient practice include: There have been no further abusive incidereported since the surveyor exited. Resident I has shown negative impact related to the documented incident. LPN # been individually education related to the following of fact policy. Other residents that have the potential to be affected have been identified by: Potentially all residents of be affected. However, there been no allegations or observations of incidents of abuse with any other resident since the surveyor exited. The measures or systemic chart that have been put into place ensure that the deficient practice does not recur include: The policy related to	icy. for elents n no elents ility ed ould have ts ne	06/29/2011

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPL		(X2) MI	JLTIPLE CON	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	IBER:	A. BUII	DING	00	COMPLETED
		155621		B. WIN			06/16/2011
NIA 77 07 1	DROLUBER OF SUPER-	<u> </u>		-		DDRESS, CITY, STATE, ZIP CODE	
NAME OF 1	PROVIDER OR SUPPLIEF	C				OCKER DR	
PINE HA	VEN HEALTH AND	REHABILITATION	CENTER		EVANSV	/ILLE, IN47720	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIE	ENCIES		ID	DDOMDERS BY AN OF CORPROSE	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDE	D BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFO	ORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	2. On 6/13/11 at	10:30 A.M., the				how to appropriately interver	ie
		ovided a "Facility	7			related to any allegation of a	buse
	Incident Reporting Form," sent to the Indiana State Department of Health on 6/10/11. The form included: "Brief					has been reiterated with all	
						nursing staff members. The in-service was designed to a	ecura
						a thorough understanding of	•
		ncident:At 2:50				regulation including the repo	
	_					of abuse to the facility	
	_	oonded to resident				Administrator and assuring the	•
	_	t stated that nurse	had hit			any personnel against which	
	her. Night super					allegation was made are rem	loved
	allegations" A	n accompanying				from duty pending the investigation. <i>The corrective</i>	,
	statement, dated	6/10/11, indicated	d, "At			action taken to monitor	
	2:50am [sic] [CNA # 2] responded to					performance to assure	
	resident's call lig	tht and states that	resident			compliance through quality	,
	_	y hit me again' and				assurance is: An	
	I .	n her. [LPN # 2], r				updated Performance	
	1	notified and spoke	-			Improvement Tool will be utili	•
	_	-				to review the proper following	g of
		s well as resident.	-			the abuse policy, including removing any employees from	m the
	^	nt was 'pleasant ar				schedule pending investigation	
	_	meAt approx 9:				based on the allegation that	
		r, the ADON, and	the			been made. The tool will be	
	social worker me	et regarding the				utilized to review any allegati	•
	incidentNo oth	er alert/oriented r	esidents			abuse. The Administrator, or	•
	had complaints of	of mistreatmentS	SW			designee, will complete this a	• • • • • • • • • • • • • • • • • • •
	[social worker] a	also spoke with res	sident			as any allegations occur for t next 6 months. Any issues	ile
	1	nt did not appear t				identified will be immediately	
	1 -	ncident last night.				addressed. The Quality	
	1	ed that she may ret	_			Assurance Committee will re	view
	work as schedule	•	.u.ii tO			the tool at the scheduled me	<u> </u>
	work as schedule	Ju.				following the completion of the	•
	A C 11: 115 1	G 11:	r · .			tool with recommendations a	
		oyee Counselling				needed. The date the system changes will be completed:	•
		1/11 and given to				June 29, 2011	
	2, indicated, "	Type of Occurrenc	ee:			55.10 20, 2011	
	Failure to immediately initiate suspension						
	of staff member	when knowledge	was				
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete	Event ID:	 I44K12	Facility II	D: 000442 If continuation sl	neet Page 9 of 18

If continuation sheet Page 9 of 18

l	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	lì '	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3400 S	ADDRESS, CITY, STATE, ZIP O TOCKER DR VILLE, IN47720	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	policy review - v Reporting Procedalleged to have a immediately be stime worked. The the staff member suspension"  On 6/14/11 at 12 Administrator procedure that RN # 1 worked.  On 6/16/11 at 6:20 with RN # 1, she her night supervious A.M. on 6/10/11 complained of Romain indicated she did resident's room for shift, but did workshift.  This deficiency we 5/5/11. The facil	tion Discussed: Abuse with special focus on dures "Any staff member abused a resident will suspended from further e individual in charge of will initiate the covided documentation at the sed from 6/9/11 at 11:01 at 8:03 A.M.  25 A.M., during interview a indicated she notified as a approximately 3:00 that Resident I had N # 1 hitting her. RN # 1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/16/2011		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0282 SS=D	facility must be proin accordance with plan of care. Based on intervioral facility failed to for positioning wheelchair as ord for 1 of 4 resider sample of 8. Res	dered by the physician, ats reviewed for falls, in a sident A	F0282	F282 It is the practice of Pi Haven Health and Rehabilitation Center to as that the residents' care pla are followed appropriately accordance with the asses needs. The corrective actio taken for those residents for to be affected by the defici practice include: Resident in no longer a resident of the fa	sure ns in sed on ound ent #A is acility.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

I44K12

Facility ID: 000442

If continuation sheet

Page 11 of 18

li ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	TED
		155621	B. WIN			06/16/20	11
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIEF	₹		1	TOCKER DR		
PINF HA	VFN HFAITH AND	REHABILITATION CENTER		1	VILLE, IN47720		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG	+		+	TAG	-		DATE
		3/11 at 11:20 A.M.			potential to be affected have		
	Diagnoses include	ded, but were not limited			been identified by: All resid have been reviewed to assu		
	to, Dementia, Parkinson's disease, and				that they are receiving service		
	Epilepsy.				accordance with the plan of		
					The CNA assignment sheets		
	A Physician's or	der_dated 4/15/11			appropriately address reside	ents'	
	A Physician's order, dated 4/15/11, indicated, "May use deluxe tray [with]				needs based on the assessr		
	1				and a monitoring system has		
	1 -	imps to w/c to aide [sic]			been implemented to assure		
	in positioning du	ie to poor posture."			interventions are appropriate	eiy in	
					place. The measures or systemic changes that hav		
	A Care Plan, initially dated 5/23/09 and updated 4/15/11, indicated a problem of				been put into place to ensu		
					that the deficient practice of		
	"Potential for fal	lls R/T [related to]:			not recur include: The		
		d unassisted. History of			interdisciplinary team will be		
	1 -	oses balance easily.			reviewing every fall to assure	e that	
	l -				appropriate interventions are		
	1	" The Interventions			place based on the possible		
		11 Deluxe tray [with]			cause of the fall. The plan o		
	1 7	amps to w/c to aide [sic]			care and the CNA assignme sheets will be updated as	'''	
	in positioning d/	t [due to] poor posture."			needed. The nursing staff h	as	
					again been in-serviced relate		
	Nurse's Notes, d	ated 4/25/11 at 2:35			providing services to our		
	A.M., indicated,	"Gotten up in w/c in TV			residents in correlation with	the	
		oise resident had fallen			written plan of care. In addit		
	1	aceration to forehead			there will be additional emph	nasis	
		3 cm [centimeters]			for new CNA's related to	hooto	
					reviewing their assignment s so that they are aware of the		
	1 -	ear 0.1 cm edges			of care established for the	, piaii	
		nd] steri striped [sic]			resident. There will be routing	ne l	
		Small am't [amount]			monitoring via rounds by nur		
	bleeding from no	oseHas red bruise area			and nursing administration to		
	[approximately]	2 cm diameter on [right]			assure that safety devices a	re in	
	knee"	-			place and functional in		
					accordance with the residen		
	On 6/13/11 at 12	2:15 P.M., the ADON			plans of care. The corrective action taken to monitor	e	
	1	-			performance to assure		
	(Assistant Direct	tor of Nursing) provided			periormance to assure		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	OVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155621		A. BUILDING 00		COMPLETED		
				B. WING		06/16/2011		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					TOCKER DR			
PINE HA	VEN HEALTH AND	REHABII ITATION CENTER		I	VILLE, IN47720			
PINE HAVEN HEALTH AND REHABILITATION CENTER			EVANSVILLE, IN47720					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
TAG			+	TAG		DATE		
		ident Report," dated			compliance through quality			
	4/25/11. The rep	ort included: "Resident			assurance is: A Performance Improvement Tool has been			
	attempting to get	up unassisted several			initiated that will be utilized to			
	times wanting to	get upresident gotten			randomly review 5 residents			
	up per CNA in w				comprehensive assessment	I		
		-			correlation with the plan of ca	<b>.</b>		
	loungeHeard noise, resident on floor, w/c in normal positionAdditional comments and/or steps taken to prevent recurrence: Education to new staff importance of CNA assignment sheet to keep on @ all times" During interview at that time, the ADON indicated he was				assure that the pertinent			
					information based on the			
				assessment is accurately communicated and being				
					followed in accordance with	the		
					residents' identified needs. S			
					device placement and function			
					will be specifically identified			
	not employed by	the facility on $4/25/11$ ,			the monitoring form. Nursing			
	and did not have	additional information.			Administration, or designee,	<b>.</b>		
					complete this tool weekly x3,	• • • • • • • • • • • • • • • • • • •		
	On 6/16/11 at 6:2	25 A.M., during interview			monthly x3, then quarterly x3 areas identified via the audit	· •		
		_		be immediately corrected. The				
	with RN # 1, she indicated she was the nurse working when Resident A fell on		Quality Assurance Committee will					
	•	indicated a "new CNA"			review the tool at the schedu			
					meeting following the comple			
		esident to a wheelchair,			of the tool with recommenda	tions		
	•	the lap tray on the			as needed. The date the			
	wheelchair as or	dered.			systemic changes will be completed: 6-29-11			
					Completed. 0-29-11			
	This Federal tag	relates to Complaint						
	IN00088724.	_						
	This deficiency v	was cited on 4/14/11. The						
	<u>-</u>	implement a systemic						
		-						
	pian of correction	n to prevent recurrence.						
	3.1-35(g)(2)							

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155621			A. BUILDING	00	06/16/2011	
			B. WINGSTREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER		l	FOCKER DR		
PINE HA		REHABILITATION CENTER	EVANS'	VILLE, IN47720		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
F0323 SS=D	environment rema hazards as is poss receives adequate devices to prevent Based on intervie facility failed to a for positioning w wheelchair, causi and obtain a lace	ew and record review, the ensure a lap tray utilized ras placed on a ling the resident to fall ration on her forehead, its reviewed for falls, in a	F0323	F323 It is the practice of Pin Haven Health and Rehabilitation Center to ass that the resident environme remains as free of accident hazards as possible, and ex resident receives adequate supervision and assistance devices to prevent accident The corrective action taken	sure ent : ach ets.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155621 06/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3400 STOCKER DR PINE HAVEN HEALTH AND REHABILITATION CENTER EVANSVILLE, IN47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Findings include: those residents found to be affected by the deficient practice include: Resident #A no The clinical record of Resident A was longer resides at the facility. reviewed on 6/13/11 at 11:20 A.M. Other residents that have the Diagnoses included, but were not limited potential to be affected have been identified by: All residents to, Dementia, Parkinson's disease, and have been reviewed to assure Epilepsy. that they are receiving services in accordance with the plan of care An annual Minimum Data Set [MDS] and assessed safety devices. The CNA assignment sheets assessment, dated 3/19/11, indicated appropriately address residents Resident A had a short-term and needs based on the assessment long-term memory problem, was and a monitoring system has moderately impaired in cognitive skills been implemented to assure that interventions are appropriately in for daily decision-making, was place. The measures or non-ambulatory, and required extensive systematic changes that have assistance of one staff for transfer. been put into place to ensure that the deficient practice does A Physician's order, dated 3/31/11, not recur include: The interdisciplinary team will be indicated, "OT [occupational therapy] reviewing every fall to assure that eval [evaluation] only for evaluation of appropriate interventions are in improvent [sic] of positioning in w/c place based on the possible [wheelchair] (extreme leaning forward)." cause of the fall. The plan of care and the CNA assignment sheets will be updated as An OT note, dated 4/1/11, indicated, needed. The nursing staff has "...Reason for Referral:...multiple medical again been in-serviced related to complexities affecting positioning in providing services to our residents in correlation with the wheelchair, general weakness and written plan of care. In addition. postural fatigue requiring OT intervention there will be additional emphasis due to severe leaning and decreased safety for new CNA's related to in wheelchair...." reviewing their assignment sheets so that they are aware of the plan of care established for the A Physician's order, dated 4/15/11, resident. There will be routine indicated, "...May use deluxe tray [with] monitoring via rounds by nurses quick release clamps to w/c to aide [sic] and nursing administration to

000442

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155621 06/16/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3400 STOCKER DR PINE HAVEN HEALTH AND REHABILITATION CENTER EVANSVILLE, IN47720 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE in positioning due to poor posture." assure that safety devices are in place and functional in accordance with the residents' A Care Plan, initially dated 5/23/09 and plan of care. The corrective updated 4/15/11, indicated a problem of action taken to monitor "Potential for falls R/T [related to]: performance to assure compliance through quality Attempts to stand unassisted. History of assurance is: A Performance previous falls. Loses balance easily. Improvement Tool has been Unsteady gait...." The Interventions initiated that will be utilized to included: "4/15/11 Deluxe tray [with] randomly review 5 residents' comprehensive assessment in Quick release clamps to w/c to aide [sic] correlation with the plan of care to in positioning d/t [due to] poor posture." assure that the pertinent information based on the Nurse's Notes, dated 4/25/11 at 2:35 assessment is accurately communicated and being A.M., indicated, "Gotten up in w/c in TV followed in accordance with the lounge. Heard noise resident had fallen residents' identified needs. Safety out of w/c. Has laceration to forehead device placement and function [approximately] 3 cm [centimeters] will be specifically identified on the monitoring form. Nursing length, width linear 0.1 cm edges Administration, or designee, will approximated [and] steri striped [sic] complete this tool weekly x3, [after] cleansing...Small am't [amount] monthly x3, then quarterly x3. Any bleeding from nose...Has red bruise area areas identified via the audit will [approximately] 2 cm diameter on [right] be immediately corrected. The Quality Assurance Committee will knee...Denies pain except to head [and] review the tool at the scheduled nose...Assisted back into w/c by staff x meeting following the completion [two]." of the tool with recommendations as needed. The date the systemic changes will be The resident was transferred to the completed: 6-29-11 hospital on 4/25/11 at 4:00 A.M., and returned the same day at 7:10 A.M., with the steri strips left in place on the resident's forehead. On 6/13/11 at 12:15 P.M., the ADON (Assistant Director of Nursing) provided

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

144K12

Facility ID: 000442

If continuation sheet

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AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  06/16/2011		
NAME OF PROVIDER OR SUPPLIER  PINE HAVEN HEALTH AND REHABILITATION CENTER			B. WING 000/10/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	)N	
	4/25/11. The rep attempting to get times wanting to up per CNA in w loungeHeard n w/c in normal per comments and/or recurrence: Educi importance of Clikeep on @ all tir at that time, the not employed by and did not have  On 6/16/11 at 6:2 with RN # 1, she nurse working w 4/25/11. RN # 1 transferred the reand did not place wheelchair as or On 6/15/11 at 10 Director of Nurs current facility p Prevention," data included: "Policy are safe and that measures are initinjuries related to This deficiency was a surrent of the company of the compan	oise, resident on floor, ositionAdditional or steps taken to prevent eation to new staff NA assignment sheet to mes" During interview ADON indicated he was the facility on 4/25/11, additional information.  25 A.M., during interview or indicated she was the shen Resident A fell on indicated a "new CNA" esident to a wheelchair, or the lap tray on the dered.  245 A.M., the Assistant ing [ADON] provided the olicy on "Falls ed 9/08. The policy or, To ensure that residents appropriate preventive tiated to minimize					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	l l	e survey pleted /2011	
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  3400 STOCKER DR  EVANSVILLE, IN47720				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	plan of correctio	n to prevent recurrence. relates to Complaint					